COLORADO
Office of Behavioral Health
Department of Human Services
Nancy VanDeMark, PhD., Director
Liza Tupa, PhD, Deputy Director Community Programs

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
LEVEL I AND LEVEL II EDUCATION AND TREATMENT

Please PRINT your full name, including your middle name. Your signature is required. (Form does not need to be notarized). Please allow 7 – 10 working days to receive written notification of the results of your records.

FIRST NAME: _____ MI_____ LAST NAME: _____

NICK NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: _____OR E-MAIL ADDRESS: _____

NAME OF AGENCY OR AGENCIES ATTENDED: _____
Month and year that you began your education/treatment: _____
Month and year that you completed education/treatment: _____
Date of your last DUI/DWAI offense in Colorado: _____

I authorized the Office of Behavioral Health (OBH), Colorado Department of Human Services to release any treatment records. This information concerns attendance and completion of alcohol and/or drug education and treatment. I authorize OBH to give this information to me for the purpose of verifying such attendance and completion. This authorization for release of information expires 90 days after the date of my signature.

SIGNATURE: _____ WITNESS: _____
DATE: _____ DATE: _____

PLEASE RETURN THIS COMPLETED FORM TO:

Jackie L. Urioste, Provider Liaison
3824 W. Princeton Circle
Denver, CO 80236
Phone: (303) 866-7484
Fax: (303) 866-7481
Jackie.urioste@state.co.us

OR

David Corral, Provider Liaison
3824 W. Princeton Circle
Denver, CO 80236
Phone: (303) 866-7430
Fax: (303) 866-7481
David.corral@state.co.us

For OBH use only

Date consent form received: _____ Date DRS Sent: _____

No record found: _____